

**BECHTEL NEVADA-WMD TRAINING COURSE  
RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**

Name \_\_\_\_\_ SSN \_\_\_\_\_ Date \_\_\_\_\_

Employers Name and Address \_\_\_\_\_

Job Title \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Glove Size \_\_\_\_\_ Tyvek Suit Size \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Boot Size \_\_\_\_\_

Are you trained to wear a respirator? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you trained to wear Self Contained Breathing Respirator (SCBA) \_\_\_\_\_ Yes \_\_\_\_\_ No

**TO BE COMPLETED BY PHYSICIAN OR COMPANY MEDICAL REPRESENTATIVE**

<b><u>Does the patient now have or have they ever had any of the following:</u></b>	<b>YES</b>	<b>NO</b>
1. Cardiovascular Disease	1. _____	_____
2. Pulmonary Disease	2. _____	_____
3. Smoke Tobacco	3. _____	_____
4. Persistent Cough	4. _____	_____
5. Heart Trouble	5. _____	_____
6. Shortness of Breath	6. _____	_____
7. History of Fainting or Seizures	7. _____	_____
8. High Blood Pressure	8. _____	_____
9. Diabetes	9. _____	_____
10. Fear of Tight or Enclosed Places	10. _____	_____
11. Sensation of Smothering	11. _____	_____
12. Heat Exhaustion or Heat Stroke	12. _____	_____
13. Ruptured Ear Drum	13. _____	_____
14. Defective Vision	14. _____	_____
15. Defective Hearing	15. _____	_____
16. Contact lenses or glasses	16. _____	_____
17. Taking Prescription Medication	17. _____	_____
18. Problems wearing a respirator	18. _____	_____
19. Other conditions that might interfere with respirator use or limit work ability	19. _____	_____

Please explain any YES answers:

I approve/do not approve (circle one) the above named person to wear a respirator (50 lbs) and protective clothing (sealed impermeable suit) and engage in activities to include: walking in protective clothing, lifting equipment and casualties, conducting physical activities associated with emergency response operations, in a desert climate. **FOR TRAINING PURPOSES ONLY** for participation in the Bechtel Nevada WMD course.

Physician Signature: \_\_\_\_\_ License Number: \_\_\_\_\_

**OR**

Company Medical Representative: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

**Privacy Act Statement**

The information requested on this form is protected by the Privacy Act of 1974. The purpose for requesting this information is to enable proper processing of your information for access to the U.S. Department of Energy, Nevada Operations training facilities. Failure to provide the requested information may preclude processing your training request.